Testimony to the Appropriations Committee February 25, 2015

Submitted by: Joseph Salvio, RN representing New England Homecare

Co Chairs: Senator Bye; Representative Walker

Good Evening Senator Bye, Representative Walker and honorable members of the Appropriations Committee. I am Joseph Salvio, RN, Primary Care Behavioral Health Nurse with New England Home Care.

There are three main points on which this testimony will focus.

1. Patient Population
2. Impact of the Changes Proposed by Governor Malloy
3. Opportunities for Moving Forward

Patient Population

- The majority of patients in the behavioral health home care population are living with serious mental illness and are fragile.
    - These patients are living with diagnoses including Schizophrenia, Psychosis, Bipolar Disorder, Major Depression, Chronic Substance Use/Abuse and many others
    - Their care is often additionally complicated by serious medical conditions such as Diabetes, Congestive Heart Failure, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Various Cancer diagnoses and others.
- Patients in the behavioral health population are most often indigent and have minimal if any support available to them from family or others.
    - Family members who are involved in a patient's life often have extensive behavioral health and/or medical conditions of their own with which they are living and thus are unable or incapable of providing support to anyone beside themselves.
    - The only support available to these patients is that which they receive from their home care nurses.
- Providing Health Care for patients in this population is complex and resource intensive.
    - It involves establishing relationships and coordinating care, on a daily basis with multiple physicians (Behavioral Health, Primary Care, Specialists), Therapists, Social Workers and others.
    - Monitoring care orders between multiple physicians, making certain that all members of a patient's care team are aware of the care needs of the patient as well as the care received and interventions of each member of the team. Physicians and other care givers are often unaware of the multiple practitioners treating a patient and more importantly unware of the care orders, including medications that a given practitioner has provided to the patient.
        - It is the responsibility of the nurse to coordinate these multiple facets of care, monitor the effectiveness of the treatment and be the first-hand eyes on the patient.
- Goal of Home Care is to achieve a maximum level of independence for the patient
    - Maximum independence varies for all patients
        - Motivated patients with stable conditions and proper support can achieve higher levels of independence and require less intensive care and oversight

        - Patients with long term illness with minimal support or motivation achieve lower levels of independence or require ongoing close monitoring in order to maintain stability.
        - We must align expectations with the reality of the patient's condition and circumstances when establishing goals.

Impact of the Proposed Changes

- Markedly reducing reimbursement for behavioral health home care services and channeling patient care to assistant and entry level caregivers, has the potential to disrupt and break down the system that is currently in place.
    - The existing system generally works well.
    - Patients are maintained in the community avoiding costly in-patient, acute care services.
    - The existing system cannot sustain the proposed reduction.
    - Homecare companies cannot service T19 patients with the recommended reimbursement structure.
    - Patients will be left without effective care – patients and the system will be jeopardized.
        - Without proper care patients may decompensate
        - The result will be an increase in patients requiring emergent and acute services.
            - Ambulance Transport
            - Emergency Department treatment
            - In-patient Treatment
        - Unintended consequences
            - Behavioral Health crisis often results in police intervention
        - In-patient facilities, emergency departments and ambulance companies are all struggling to provide care for patients who are in crisis but do not have adequate health coverage.
            - If home care patients cannot be maintained in the community they will seek care in urgent/emergent settings. These settings are costly, currently struggling with funding themselves and in a compromised position to handle an increase in patients with acute behavioral health and medical needs.
    - Any progress made in maintaining care for T19 behavioral health patients in the community is potentially jeopardized.

Opportunities

- There is a population of patients who can be managed using well trained, well managed medical/nursing assistants.
    - It is a subset of the current population.
        - Ideal patients are those that have achieved stability and compliance with a treatment plan can be maintained without daily RN oversight.
    - We need to align expectations.
        - As mentioned earlier, most patients in the population carry complex behavioral health and medical diagnoses. They carry long term, chronic conditions and have minimal support and available to them.
    - We must refocus our effort to identify appropriate candidates and carefully transition them to lower intensity care management.

- We must be realistic.
    - These are chronic patients and they will likely pass in and out of a reduced care model over the course of their treatment.
    - We should not expect to transition a high volume of patients into a reduced care model over a short period of time.
    - Doing so would likely be high risk and costly exercise.
    - The best course is to carefully identify patient candidates, carefully identify and train nursing assistants who can effectively provide care, build a system that can support the model and safely provide high quality care to these patients.

Summary

- The population of patients with which we are dealing is a remarkably challenging population.
- They are vulnerable and fragile.
    - Patients in this population have long-term chronicity, complex behavioral health and medical diagnoses, and minimal support.
- These patients require complex homecare in order to maintain their lives with the community and avoid the need for high cost care in an emergent or acute setting.
- Implementing the current recommendations has the potential to adversely impact the health care system, jeopardize the already vulnerable communities where these patients live, leave these patients without services and burden a system that is already stretched for resources.
- A reasonable solution is to align expectations for modifying the current home care management system, identify patients that can be safely managed with less intensive personnel and safely transition patients that are appropriate into a less intensive more cost effective protocol.